however, by the administration of a clyster, or, by the child, if old enough, pressing down as at stool. Polypus of rectum is distinguished from dysentery chiefly by the absence of tenesmus and fever; from prolapsus ani by the ring-shaped, rose-like, or longish cylindrical form and painful character of the prolapsed portion, its augmentation in size by the tenesmus it gives rise to; the edges finally spreading sidewise, and presenting, usually, in the centre or on one side the opening into the rectum. The seat of the polypus is usually between the inner and outer sphincters, and inserted at the posterior wall of the intestine. The prognosis is always favourable. The removal of the polypus is by the application of a ligature, and subsequently the tearing away, or not, of the tumour. The latter may be held firmly during the operation, by a forceps, or by what Dr. B. prefers, a finely constructed clamp, as suggested by Serres.—*Centralblatt f. d. Med. Wissenschaften*, from *Jahrb. f. Kinderheilk.*, N. F. IV. 1871. D. F. C.

OPHTHALMOLOGY.

59. *Colour Blindness from Diseases of the Eye.*—In *The Royal London Ophthalmic Hospital Reports* for Nov. 1871, we find an account of the researches of Dr. X. GALEZOWSKI, as to the effects of diseases of the eye on the perception of colours, taken from the *Annales D'Oculistique* for May and June, 1871.

The result of his examination of 766 patients suffering from alterations in the fundus oculi has been to establish three varieties of chromatic defect: A. Morbid "Contrast of Colours." B. Colour Blindness. C. Scotomata for Colours. A. The name "contrast" of colours has been given to the mutual opposition between different colours when seen together, or when seen successively, by which a mixed tint (complementary colour) is produced unlike either of those looked at. This physiological phenomenon is met with, under exceptional circumstances, in healthy eyes, but analogous phenomena result from the morbid conditions brought about by the abuse of alcohol. The impression produced on the retina by one colour remains too long, so that another cannot be seen properly till a considerable interval has elapsed. After the patient has shut his eyes for a while he can tell any colour well. If such a patient be told to look at several colours at once, he will see nothing but confusion, though he will be able to recognize any one separately. B. Colour blindness. 1. In optic atrophy. This is the disease in which colour blindness is most frequently met with. Of 156 patients with optic atrophy, 66 were unable to detect one or many colours, or even any at all.

Green is the first colour which fails to be recognized, and afterwards red. Nearly all patients suffering from progressive atrophy take the green for gray, and as the malady advances, the red becomes less and less perceptible, changing into brown, and then into black. Blue is perceived for a very long time, and yellow is detected almost as long as the patient can see light. As the yellow occupies so large a part of the solar spectrum, it may also have a larger surface than the other colours in the retinal cones, so that, though they are atrophied, they still perceive the yellow. The author has only met with total colour blindness in two cases. The atrophy, consecutive to neuritis or neuritis itself, more rarely gives rise to colour blindness. Alcoholic amblyopia may produce complete colour blindness, or only for a certain colour, and the blindness varies from day to day; green is generally confounded with gray. Glaucoma gives rise to colour blindness only exceptionally. 2. Hysterical amblyopia. Cases of this affection are given, and an account of the effect on perception of colours. One fact noted is, that in all the cases, besides the loss of perception of yellow and blue, all the others cease to be seen; often, even, the patients cannot tell black and white. 3. Optic neuritis, hemiopia, and different varieties of cerebral amblyopia. These are generally exempt. The loss of the faculty of distinguishing yellow indicates most frequently a syphilitic cause, and the neuritis is then accompanied by choroiditis or retinitis. 4. Albuminuric and glycosuric retinitis. Colour blindness in these cases is very inconstant. 5. Congenital retinitis pigmentosa. This does not habitually lead to colour blindness. 6. Syphilitic choroido-retinitis. This is one of the affections which most frequently lead to colour blindness. The colour generally mistaken is yellow. Blue and green are also very frequently not recognized. The explanation of these phenomena is to be looked for in the wide-spread inflammation of the whole retina and choroid at once. Partial syphilitic inflammations of the retina, as well as certain forms of choroiditis, do not produce any chromatic defect. C. Central scotomata for colours. This variety is probably due to alterations of the yellow spot, and in certain cases to atrophy of the optic disk. Apoplexies, on the yellow spot, lead to temporary or permanent loss of central perception of colour. In ten cases of idiopathic retinal hemorrhages, the patients could not perceive any colours when they looked straight at them, but when they looked with the lateral portions of their retinæ, they could detect the principal colours without difficulty. Detachment of the retina, not materially affecting the sight, does not affect the perception of colours. In a certain number of cases the patients have complained that either before or very soon after the occurrence of detachment of the retina, they have, for days or weeks, or even longer, seen every object coloured blue or violet. The light of a candle or of the gas seemed to them to be of a fine blue colour, such as azure or ultramarine blue.

[It may be remembered that the editor of this Journal, in the number for August, 1840, called attention to inability to distinguish colours, resulting from disease of the eye, and he was, we believe, the first to do so, that inability having previously been supposed to be always a congenital defect. He studied this inability first in a patient during *recovery*, and noted the *succession* in which colours were distinguished. Dr. Galezowski has recently studied the defect in patients *losing* their ability to distinguish colours during the progress of disease, and noted the order in which this inability manifested itself. The results of the two strikingly accord. Dr. Hays noticed that on recovery the first colour his patient was able to distinguish was yellow, next blue, and then red. Dr. G. observed that in his patients the last colour they were able to recognize was yellow, before that they recognized blue, and still earlier in the disease also red.

Dr. H.'s observations were recorded still more fully in the edition of Lawrence's *Treatise on the Diseases of the Eye*, published by Blanchard & Lea, in 1854.]

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60. *Form of Amaurosis supposed to be due to Tobacco.*—Mr. JONATHAN HUTCHINSON published in the first volume of the *London Hospital Reports* a series of cases of amaurosis supposed to be connected with tobacco, and afterwards in the *Transactions of the Medico-Chirurgical Society* for 1867 a statistical summary of his experience during the three intervening years, and in the *Royal London Ophthalmic Hospital Reports* for November, 1871, he publishes a third series of cases, 29 in number, of the same kind, including most that came under his notice during the four years, 1867, '8, '9, and '70.

"Any one," he says, "who may take the trouble to compare the cases given in these three reports, will be struck by their similarity, and by the remarkable confirmation which the two later papers give to the conclusions of the first. A very great disproportion in the numbers of the two sexes who become the subjects of "idiopathic amaurosis," was one of the facts brought out (for the first time) by my first report. In it the numbers were 37 men and 3 women, and in the second they were 34 men and 5 women. In the present one they will be found to be 28 men and only one woman. There can, therefore, be no reasonable doubt that we have to deal with a formidable type of symmetrical amaurosis which is almost exclusively confined to the male sex. For myself, I may briefly avow that I have scrupulously investigated other possible causes, and that I feel no hesitation in believing that in most of these cases tobacco is the real one.

"The facts as regards the one woman whose case is included in the present series are extremely interesting. Her case in every feature resembled those which, in males, I attribute to smoking, and upon this point I had made special comment to those who were attending my class. After I had done so, she informed me that one of her sons had formerly been my patient, and that a nephew had been under the care of Mr. Hulke. I referred to my notes, and Mr. Hulke was kind enough also to refer to his, and we each found that the cases had been diagnosed as tobacco amaurosis. In each the patient was a young man and a smoker. Now, the lesson of these facts seems to me to support the opinion I have long held, that when tobacco causes blindness, it does so in virtue of an idiosyncrasy. It is by no means improbable that such idiosyncrasy will be found occasionally in several members of the same family, and further, that it may involve liability to suffer from other influences besides tobacco-smoking. Thus, then, we have two young men, cousins, attacked by amaurosis at an early age in virtue of an idiosyncrasy rendering them liable to special poisoning from tobacco; and we have a woman, who had never smoked, the mother of one and aunt of the other, at a much later period of life becoming the subject of a similar form of nerve disorder in virtue of the same peculiarity of diathesis acted upon by a different exciting cause. In her not improbably the exciting cause was the disturbance consequent upon the cessation of menstruation.

"Holding the opinion that there must be some pre-existing peculiarity in the nervous systems of those who become the subjects of tobacco amaurosis, I have been very anxious to discover, if possible, whether it reveals itself by any other signs. The only points in this direction to which I feel at present inclined to attach any importance are the following. Not unfrequently it will be found that these patients have had unusual difficulty in learning to smoke, and have throughout life displayed special susceptibility to its influence, and that also they have often been beyond the average liable to suffer from sea-sickness. In the tabular statement some information will in many cases be found given on these points. My attention to the matter of sea-sickness was first given in consequence of the statements of some patients who were sailors, and who specially referred to it.

"We have, during the last few years, made the observation that those who suffer are, almost invariably, smokers of *shag*, the most deleterious form of tobacco. As regards the results from disuse of tobacco, my impression is strong, that almost invariably, when the disuse is real and complete, the state of vision improves. I cannot exaggerate the expression of my conviction as to the duty of urging immediate and complete abstinence in the early stages of this most serious malady. Many of my patients came too late, having continued to smoke until the disease was far advanced. I have never seen a case in the early stage in which the disease went on to blindness if the patient had strength of will to give up the habit. In a large majority of those in whom, according to the patient's account, the habit was wholly abandoned, I had reason to suspect that it was only reduced. My experience on this point fully confirms that of Dr. Mackenzie, that there are those 'who would rather smoke than see.' It is very few, however, who have the honesty to admit their inability to give up the habit, and hence a very annoying source of fallacy in our inferences as to the effect of treatment."

In the five worst cases, each of the patients had been a *smoker for a long time;* in several of the cases the *quantity of tobacco smoked had been* comparatively small. There were *other signs of intolerance of tobacco* in these five cases. In all the worst cases the patients had used alcoholic drinks, and two of them had been great drinkers. In the worst case of all, the patient had smoked for twenty-four years, but had not smoked as much as most of the others; but he had had difficulty in learning to smoke, and smoking had often in after-life made him sick and nervous.

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61. *Anæsthesia of the Retina.*—Dr. A. SICHEL, Jr., understands by this term a failure of the power of transmitting sensations to the brain, with a want of susceptibility of the retina itself. The retina perceives the impression, but the patient remains unconscious of it. The attack generally comes on suddenly,

follows some severe moral impression, and occurs in those who have a sensitive nervous organization. Some few days generally elapse after a fright or loss of consciousness before the failure of sight ensues. There are no objective symptoms of the affection; the ophthalmoscope reveals no changes; a sensation of light is produced by pressure on the eyeball in any position, and the pupils are normal. The field of vision alone furnishes us with valuable information; generally there is either concentric limitation or scotomas or manifold variations. The patient may complain of any degree of loss of sight, from simple amblyopia to complete amaurosis. Often the acuity of vision is only reduced to one-half or one-third of the normal standard. It is not diminished by artificial light, but is often increased by the employment of coloured glasses. Various "hysterical" symptoms are often present. The duration is uncertain, and the severity of the malady is subject to variations at different times, but its course is usually benign, and ends in all cases in a cure. The treatment should be of a general character. Two cases are narrated: the first is given in great detail, and was that of a man 28 years of age, whose history extended over a period of twelve years. At the commencement he was seized with loss of sight of the right eye, which came on in the course of a few days, and lasted about a year. Four years later a similar attack occurred. He consulted M. Sichel, the elder, who ordered tonic remedies. The patient recovered at the end of about eight months. Seventeen days before he finally came under care the patient had been seized with a sunstroke while forming one of a picnic party. The next day he suffered from loss of consciousness for two hours, accompanied by vomiting and purging. Five days later he was seized with intense pain in the head, immediately followed by progressive failure of sight of the right eye. At the time of examination the vision of the right eye was completely lost. The chief point of interest was the variation in the extent of the field of vision of the left eye, of which numerous charts are given. At times there was an inability to distinguish certain colours. Von Graefe, being in Paris, was consulted, and M. Sichel told him he suspected that the amaurosis was simulated. The diagnosis of retinal anæsthesia was confirmed, and treatment by oxide of zinc recommended (four grains divided into 200 pills, one to be taken thrice daily, and the dose increased, by one pill every two days, to four pills three times a day). Gradual recovery followed. The sight of the right eye returned, and the field of the left became normal. M. Sichel sums up the case, and remarks that it would be difficult to find a more perfect type of hysteria, and he thinks that the diagnosis of retinal anæsthesia or of hysterical amaurosis is indisputable.

The second case was very similar to the first, but the patient was a woman aged 26. The symptoms had lasted about three weeks. She had had a similar attack at the age of 8 or 9 years. She had a second one at the age of 15 or 16. Various methods of treatment were tried for the relief of the attack for which she came under care, but no good result followed till the oxide of zinc was employed. She then steadily improved. At the end of three months she returned home able to resume her occupation, that of a seamstress. She was of a highly nervous temperament, and presented symptoms of an essentially hysterical character. This case was analogous to the preceding, from the fact that the defect of sight was accompanied by hysteria; that there was an entire absence of any change in the fundus oculi; that phosphenes could be produced; that the result of objective examination was negative; and that vision returned under the influence of anti-chlorotic and anti-hysterical remedies. —*Royal London Ophthalmic Hospital Reports*, Nov. 1871, from *Annales d'Oculistique*, May and June, 1870.

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62. *The Coexistence of Aneurismal Changes in the Retina, with Aneurisms of the small Arteries of the Encephalon.*—H. Lionville communicates a note on this subject to the *Gaz. des Hôp.*, 1870, No. 36, p. 151, given in full in the *Ann. d'Oculistique*, September—October, 1870, p. 169. We select the following points:—

The author has previously shown the coexistence of small (miliary) aneurisms of the small arteries of the various parts of the body with miliary aneurisms of the small cerebral vessels (aneurismal diathesis), and he argued then, that if aneurismal changes in the vessels were dependent on an alteration in the whole arterial system, rather than on a local lesion in this or that part of the body, these aneurisms, developed in connection with a general change, might be met with in some parts accessible to our investigation, such as the retina. The retina seemed to him, in fact, to be one of the organs which it would be easy and important to investigate for the detection of this general condition, and he expressed a hope that either during life or after death its examination would reveal important information. The object of the present note is to show that such information has been obtained.

In 1868 the author communicated the results of his investigations to the Biological Society.

The first case was that of a woman, aged 87, who had had (two years before) a sudden attack of right hemiplegia, without loss of consciousness; afterwards she suffered from dizziness, flushing of the face, and headache, and she died August 15, 1868.

The bloodvessels were found in places to be very atheromatous; there were well-defined aneurismal dilatations on the meninges, and numerous miliary aneurisms on the surface and in the interior of the brain, in the cerebellum, and the pons Varolii. Examination of the right eye showed the retinal vessels to be very much dilated, gorged with blood, and tortuous; and in their course were found rounded dilatations, separate, and resembling aneurisms completely, which they were at once suspected to be, but this could only be proved on examination with a lens. The crystalline lens was opaque, otherwise, the author remarked then, these lesions might have been demonstrated by ophthalmoscopic examination.

In the following year MM. Bouchereau and Magnau showed some specimens to the Society, from a remarkable example of general aneurismal changes. The patient was a man aged 58, who drank excessively, was subject to epileptic fits, and died in one. At the autopsy there were found cerebral hemorrhages, cerebral aneurismal dilatations, retinal hemorrhages, and miliary aneurisms and spinal meningitis.

A third case the author saw in conjunction with M. Charcot. The patient was 72 years of age, and had died after slight apoplectic attacks. The autopsy revealed innumerable miliary aneurisms, scattered throughout the brain, cerebellum, pons Varolii, and the membranes. They were of all sizes, of different ages, and in many places corresponded with multiple, localized apoplexies, also of different ages. There were extensive arterial changes in various parts of the body, but also aneurisms were found in both retinæ. These aneurisms corresponded to small apoplexies infiltrated into the retina itself. Briefly, there were disseminated here and there, small zones of ecchymosis, of a rusty-yellow colour, surrounding rounded dilatations of the vessels, which could be made out very fairly with the naked eye, and could be distinctly demonstrated with a lens. Moreover, microscopic examination discovered others, which, on simple inspection, had not been recognized. Some required to be magnified 10 or 20 diameters before they could be recognized, whilst others were as large as a small pin's head, or as a tobacco seed, and one had attained the size of a small millet seed. In this case the lenses were clear, and an ophthalmoscopic examination might have been made.—*Royal London Ophthalmic Hospital Reports*, Nov. 1871.

63. *New Method of Extraction of Cataract.*—M. R. LIEBREICH, Ophthalmic Surgeon and Lecturer to St. Thomas's, in a recent lecture made some interesting observations on Graefe's operation for extraction of cataract, and described a new method for which he claims great advantages.

"The frequent occurrence of total suppuration after flap-extraction induced the celebrated operators of Moorfields Hospital to return to, and to improve, the linear extraction, which at that time had been almost abandoned. Graefe, struck with the results which Messrs. Bowman and Critchett had obtained, submitted the question to further studies, and so formed the method which is now generally adopted in England as well as on the Continent.

"There are numerous statistics which prove that in Graefe's method there is a much smaller percentage of total suppuration than in flap-extraction; also that, even in cases of very bad general constitution, weak and marastic individuals with thin and flabby cornea, the prognosis is not so unfavourable as in flap-extraction; and that the precautions we have to take after the operation, and the restrictions we have to impose upon the patient, are not so great.

"On account of these advantages of Graefe's method, it was natural that the flap-extraction was soon abandoned. To me, however, it appeared that the mechanism of Graefe's operation was still too complicated and too violent; that prolapse of the vitreous body and hemorrhage into the anterior chamber were too frequent during the operation, iritis and strangulation of the iris in the corners of the wound too frequent after it; and that the most favourable results, compared with the most favourable results in flap-extraction, were not perfect enough.

"If these inconveniences be carefully inquired into, it is found that they can all be brought back to one and the same principal cause—namely, the peripheric position of the incision. This peripheric position explains why—

"1. It is impossible to remove the lens without iridectomy.

"2. The excision of the iris is to be large and extensive, else it causes too great an inclination to prolapse of the iris.

"3. It is necessary to perform the operation above, so as to cover a part of this large pupil by the upper eyelid. The removal of the lens upwards is by far more difficult, on account of the tendency of the eye to escape upwards; and, consequently,

"4. During the whole operation, the eye has to be kept open by the speculum, and to be drawn downwards by the forceps. This is not only painful and injurious to the eye itself, but causes—

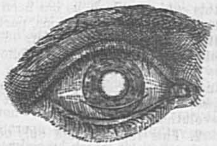
"5. Not unfrequently, prolapse of the vitreous body, to which a peripheral incision itself already tends. Prolapse of the vitreous body and hemorrhage into the anterior chamber are the chief impediments to a careful removal of all the *débris* of the cortex, and cause—

"6. Those grave forms of iritis which are sustained by the permanent irritation caused by the tumefied remainders of the lens behind the iris.

"Of those disadvantages I was perfectly aware after I had followed for a short time Graefe's original plan; and I proposed, therefore, in 1867, in an article on cataract which I wrote for the *Nouveau Dictionnaire de Médecine et de Chirurgie* (Paris, Baillière), some modifications. They are, however, but the first step I made; and in the last four years I have come, by a large series of systematic experiments, to a method which I now, after more than three hundred operations performed in this manner, consider definitely settled.

"The incision of the cornea is to be made with the smallest possible Graefe's knife, in the following manner.

"Puncture and contrapuncture are made in the sclerotic about one millimetre beyond the cornea, the whole remaining incision passing with a very slight curve through the cornea, so that the centre of it is about one millimetre and a half distant from the margin of the cornea. This incision can be made upwards or downwards, with or without iridectomy, and the lens can be removed through it with or without the capsule.



"If, as I now practise, the extraction is made downwards without iridectomy, the whole operation is reduced to the greatest simplicity, and does not require narcosis, assistance, elevator, or fixation; and only two instruments—namely, Graefe's knife, and one cystotome, with Daviel's spoon.

"What are the advantages of this method of operating?

"1. It is undoubtedly of all methods the simplest and the least painful.

"2. It is unconditionally the easiest to perform, and requires the least practice. It may, therefore, be performed by those operators who from time to time only have an opportunity of doing so; and those patients benefit by it who are unable to reach a central point in order to place themselves in more practised hands. On account of the greater facility of operating, the last pretext for reclination of cataract is removed, which, though almost universally and justly condemned, is still here and there performed.

"3. It is preferable to the flap-extraction, on account of the safer and constantly regular incision. The flap-incision scarcely ever acquires the regularity which may theoretically be demanded—even if made by the most practised operator, with the best assistance, the most enduring patient, or under chloroform—by the use of elevator and fixation instruments. Now its height or breadth is not what it is intended to be; now its position is incorrect, or the wound is irregular—indeed, part of it is due to the difficult form of the incision; but by far the greater part, according to my conviction, is due to the mechanism by which the cuneiform cataract-knife is to make the incision. A small Graefe's knife would make a flap safer and more regular than the various other cataract-knives. The incision which I designed can easily be made, in giving it in every case exactly the desired form and position—even if the patient is very restless—without assistance, without elevator or fixation. It mainly depends on the facility with which the place of the contrapuncture can be chosen, the knife drawn back and made to pierce at another point if a mistake is made in the selection of the place for contrapuncture, and in the freedom with which, in terminating the incision, the inclination of the knife can be changed if necessary.

"A little practice will enable every operator to avoid these corrections, and to make the contrapuncture, as well as the whole incision, correctly to his original plan, without subsequent alterations.

"4. Against Graefe's method it has the advantage of a more favourable position of the field for the operation, and avoids through it all the inconveniences to which I have referred, as arising out of the peripheral position of the wound.

"5. In regard to the mode of healing, it favourably contrasts, like Graefe's method, with the flap-extraction, on account of the diminished influences which age, constitution, general state of health, season, and other causes, exert; also on account of the less demand made upon the patient to remain quiet after the operation; and, above all, on account of the lesser tendency to suppuration of the cornea.

"6. The advantages of my method over that of Graefe are shown by the ultimate results obtained; by not showing a greater percentage of total suppuration than in Graefe's method, my best results are, in regard to optical and (if I may use the term) anatomical perfection, identical with the best results obtained in flap-extraction."—*Brit. Med. Journ.*, Dec. 2, 1871.

64. *Reproduction of the Crystalline Lens.*—M. MILLIOT communicated to the Biological Society of Paris, Oct. 14, 1871, the results of some experiments on this subject, which he has been for some time engaged upon. After referring to previous investigations, particularly those of Gruby, Textor, Valentin, and the conclusive experiments of Philippeaux, M. M. gave the particulars of his own, and presented the following conclusions deduced from them:—

1. The reproduction of the crystalline lens in some of the mammiferæ is incontestable. The tubes of the reproduced crystalline undergo, in their reappearance, the same phases that they do during their generation and embryonic evolution.

2. This reproduction only occurs within the capsule of the crystalline. It is in direct relation to the thickness of the cortical layers of the crystalline left after extraction, especially in the equatorial region, and in inverse relation to the age of the animals, and to the lesions of the crystalline capsule.

3. The posterior crystalline capsule seems to take no part in the reproduction of the crystalline, except perhaps in its equatorial portion.

4. This reproduction takes place even when the whole of the crystalline lens has been extracted. It commences generally towards the end of the second

week after the operation, and is completed only between the fifth and twelfth months.

5. The reproduction of the crystalline may be repeated, that is to say, it occurs after the extraction of a crystalline previously reproduced, but it is then limited.

These results are derived from more than forty experiments.—*Revue de Cours Scientifique*, Oct. 28, 1871.

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65. *Local Use of Sulphate of Quinia in Granular Ophthalmia.*—Dr. C. Bader, Ophthalmic Assistant-Surgeon, Guy's Hospital, relates (*Lancet*, Oct. 28, 1871) some experiments made with sulphate of quinia in the treatment of granular lids. As much of the salt "as would go on the point of a penknife was placed with a dry camel-hair brush, on the inner surface of each lower eyelid." No other treatment was made use of. In some cases its application was followed by severe smarting, which continued for ten or fifteen minutes; in other cases no pain whatever was felt; in all cases appeared increased purulent discharge from the conjunctiva, with shrinking of the granulations, and clearing of the surface of the cornea. The intolerance of light ceased rapidly in all cases; the dilatation of the pupils appeared in from twelve to twenty-four hours after the first application of quinia. The pupils, though dilated in ordinary light, contracted well on exposure to strong light.

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66. *Melanotic Tumour of the Eye.*—Mr. G. Lawson related to the Clinical Society of London (Oct. 13, 1871) the particulars of a case of large melanotic tumour of the eye, which had burst through the sclerotic and had extended into the orbit. He first excised the globe, and then freely applied the chloride of zinc paste for the purpose of destroying all the tissues within the orbital cavity, and thus effectually to get rid of all the cancer-germs with which those structures are in such cases generally infiltrated. The operation was performed in July of this year, and the patient was now progressing favourably towards recovery. All the tissues within the orbit sloughed, and large portions of the bony cavity have exfoliated. Mr. Lawson remarked, that when the diagnosis of melanotic tumour within the eye is made at a very early stage of the disease, the simple removal of the eye is frequently sufficient. He quoted the case of a patient in whom he had been able to recognize the tumour by the ophthalmoscope when it was scarcely of the size of a pea. He removed the eye, and now nearly three years have elapsed and there has been no recurrence of the disease in the orbit.—*Lancet*, Oct. 21, 1871.

MIDWIFERY.

67. *Instrumental Treatment of Difficult Labours.*—Dr. G. H. Kidd, President of the Dublin Obstetrical Society, in his recent address, entered at length into the question of this subject, illustrating his remarks by statistics based on the practice of the Rotunda Lying-in Hospital during the past eighty years. Dr. Joseph Clarke, who was master from 1787 to 1793, used the forceps but once in each 728 cases. As a contrast, in the three years during which Dr. G. Johnson has now been master, he has employed the forceps once in 14.74 cases. The mortality of the mothers after tedious and difficult labours has fallen from 20.21 per cent. in Clarke's time, to 7.38 per cent. of the present; and of those delivered with the forceps, from 50 to 6.86 per cent. Again, of children born by the aid of the forceps, the mortality had in the same period fallen from 50 to 4.9 per cent. That the use of the forceps was the cause of vesico-vaginal fistula, Dr. Kidd believed to be quite unfounded; on the contrary, this unfortunate accident generally resulted from not using the instrument. Though the use of the perforator and the practice of embryotomy had recently been reduced to a